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ABSTRACT

Volunteers have made significant contributions to mental health by assisting with institutional care, outpatient counseling, aftercare, and research. To describe the use of volunteers in drug abuse treatment programs, volunteers were studied by a telephone survey of administrators in 123 programs that had at least five volunteers and a single treatment modality, and by in-person interviews with volunteers and paid counselors for 15 programs. The volunteers were classified into three occupational groups, i.e., specialized professionals, counselors, and noncounseling support personnel. The results indicated that: (1) the counselor category had the largest number of volunteers; (2) volunteer professionals were often psychologists or lawyers; (3) activities of volunteer and paid staff differed in degree rather than kind; (4) drug-free and therapeutic community programs differed in background, type of volunteer, and kind of volunteer activity; and (5) main sources of volunteers were colleges, community organizations, and former clients from a program. The findings indicate a need for more volunteers as well as a pattern of successful programs using volunteers in the field of drug abuse. (NRB)

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A STUDY OF VOLUNTEERS IN DRUG ABUSE PROGRAMS

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FOREWORD

Volunteer workers have made significant contributions to mental health by assisting with institutional care, outpatient counseling, aftercare, and even research. Much effort has been expended in studying the roles of volunteer workers in the mental health field. However, little has been known about the role of the volunteer in the drug abuse field even though volunteers constitute one-fifth of all drug treatment staff and one-fourth of all drug abuse counseling staff.

This study goes a long way in clarifying volunteers' roles and activities, their backgrounds and job satisfactions. The investigators also examine the reservations paid staff feel about volunteer activity and the benefits both administrative and counseling staffs derive from their work with volunteers.

This study not only provides useful information about the current state of volunteerism in the drug abuse field but should also influence future programmatic and research activities.

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SUMMARY

The purpose of this study was to describe the use of volunteers in drug abuse treatment programs along a number of dimensions such as functions and activities, volunteer background, and staff attitude toward volunteers. Volunteers in drug abuse programs were studied in two phases: (1) a telephone survey of administrators in 123 programs meeting the criteria of having at least five volunteers and a single treatment modality; and (2) in-person interviews with volunteers and paid counselors for 15 programs. Volunteers were classified into three occupational groups:

a) Specialized professionals, including physicians, lawyers, psychiatrists, nurses, and social workers
b) Counselors
c) Support personnel with noncounseling or administrative functions.

Some of the study's findings were as follows:

- The counselor category had the largest number of volunteers.
- The two most frequently occurring types of volunteer professionals were psychologists and lawyers.
- Programs in the sample were more likely to have volunteer staff only rather than paid staff only in the categories of physicians, psychiatrists, vocational counselors, social workers, nurses, and lawyers.
- It should be noted that the activities of volunteers and paid staff differed in degree rather than kind.
- Volunteer counselors' experience with drugs ranged from 8 percent who had tried heroin to 80 percent who had used marijuana and alcohol to excess.
- Drug free and therapeutic community programs differed in background and type of volunteer and in kind of volunteer activity.
- Main sources of volunteers were colleges, community organizations, and former clients from the program.

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Introduction

Study Issues and Purposes

This is a descriptive report of a two-part investigation on the use of volunteers in drug abuse treatment programs. The study was motivated by the substantial use of volunteers in the overall staffing of drug treatment programs throughout the country. Although there have been many studies on volunteers in the mental health field, little is known about the role of volunteers working in drug abuse programs. The purpose of the study is to provide information about volunteers in the field of drug abuse. The study describes volunteer background and characteristics, functions of volunteers, comparison of volunteer functions with paid staff, drug use by volunteers, volunteer motivation and job satisfaction, and other aspects of volunteerism.

Background

Each year all drug treatment programs in the country are examined through the National Drug Abuse Treatment Utilization Surveys (NDATUS) to document, among other things, the staff composition of programs. Information is collected on the numbers of volunteer versus paid staff in each of 11 staff categories. Table 1 shows the findings for 1976, 1977, and 1978.[1]

Overall, the proportion of all staff who were volunteers in 1978 was 17 percent, a sizable drop from 24 percent in 1976. However, it still indicates a substantial dependence by the programs on volunteer participation.

The predominant category of volunteer was counselor, which represented 40 percent of all volunteers in 1976, 53 percent in 1977, and 56 percent in 1978.

Lawyers were unique in that each year there were more volunteer than paid lawyers.

A substantial number of volunteers fell into the "noncounseling" category that included, for example, hotline, social services, and clerical support workers.

The number of volunteer administrative staff fell from 14 percent in 1976 to 6 percent in 1978.

According to the Surveys of 1977 and 1978, volunteers constitute almost one-fifth of all drug treatment staff. The proportion is even higher among drug counselors, with volunteers constituting almost one-fourth of all counselors in these same years. In addition, there is a difference in volunteer use within modalities with volunteers being more involved in residential and outpatient than methadone maintenance programs.

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[1] Summaries appear in the following documents:

a. For 1977-1978, see Data from the National Drug Abuse Treatment Utilization Survey (NDATUS). NIDA Statistical Series, Series F, Number 6, Final Report, April 1978.

b. For 1976, see Data from the National Drug Abuse Treatment Utilization Survey (NDATUS). NIDA Statistical Series, Series F, Number 3, Executive Report, April 1977.

Table 1.--Actual numbers of paid and volunteer staff in treatment service units

Staffing categories	1976[1]				1977[2]				1978[3]			
	Paid		Volunteer		Paid		Volunteer		Paid		Volunteer	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Physicians	1,746	4	476	3	1,339	4	165	2	1,401	4	244	4
Psychiatrists	1,686	4	220	2	1,141	3	99	1	1,426	4	154	2
Psychologists	2,299	5	389	3	1,551	5	160	2	2,111	6	232	3
Social Workers (MSW)	2,947	6	394	3	1,946	6	312	4	2,083	6	233	3
Nurses	4,362	10	377	3	3,569	11	183	3	3,746	10	233	3
Lawyers	201	--	341	2	91	--	148	2	96	--	210	3
Counselors	13,597	30	5,78[4]	40	11,812	36	3,825	53	13,274	38	4,034	56
Degreed Counselors (BA, MA)	(4)		(4)		(4)		(4)		7,009	20	960	13
Non-Degreed Counselors	(4)		(4)		(4)		(4)		6,265	18	3,074	43
Vocational Specialists	(5)		(5)		557	2	145	2	772	2	97	1
Administrative Staff	9,657	21	1,984	14	7,603	23	389	5	7,687	22	420	6
Other	9,096	20	4,414	31	3,534	11	1,849	25	2,042	8	1,404	19
TOTAL	45,591	100	14,384	100	33,243	100	7,275	100	35,638	100	7,261	100

[1]Based on 3,878 treatment service units.

[2]Based on 3,107 treatment service units.

[3]Based on 3,248 treatment service units.

[4]There was only one category for counseling staff in 1976 and 1977 which included degreed and nondegreed counselors.

[5]This category was not included in 1976.

Note: This table was compiled from Data from the National Drug Abuse Treatment Utilization Survey (NDATUS). NIDA Statistical Series, Series F, Number 3, Executive Report, April 1977 and Series F, Number 6, Final Report, April 1978.

Method

The study was performed in 1979 in two phases: (1) A telephone survey of the administrators of nearly all the therapeutic community, outpatient drug free, and methadone maintenance treatment programs across the country which had five or more volunteers listed in NDATUS in 1978, and telephone interviews with administrators of 15 programs that had no volunteers to identify reasons for nonutilization. (2) Based on data from phase I, visits were made to 15 programs across the country in the drug free outpatient and residential modalities which made especially extensive use of volunteers. Face-to-face interviews were conducted with a variety of volunteers and with paid counselors.

For purposes of the investigation, volunteers were defined as people who work for no pay and for at least 1 hour per week in the program. Students who might be doing internships in a program were included in the definition so long as they were not being paid. In this regard, course credit was not considered pay.

The role of the volunteer covers a wide range of tasks, including community education, interagency relationships, program administration, counseling in the community, client administration, personal aid to clients, socializing with clients, psychological/psychiatric services, medical/dental services, legal services, and research.

Phase I - Telephone Survey

The programs were selected from the 1978 NDATUS File which contains data on 3,248 drug abuse treatment units representing 97 percent of all known drug abuse treatment facilities in the nation. Approximately 7,260 volunteers staffed drug abuse treatment units during that year. The two major stratification variables for program sampling were region of the country and treatment modality. The continental United States was divided into four regions for sampling, the Northeast, North Central, South, and West. This was to assure a representative sample throughout the country. Data were not analyzed by regions. Three treatment modalities were considered: drug free outpatient and/or daycare (DF), residential drug free or therapeutic community (TC), and methadone maintenance (MM). Only those programs that could be clearly identified as fitting into one of these three categories were retained for study. Multimodality programs were eliminated. By having only unimodality programs, comparisons between modalities could be made. Out of 138 programs meeting the criteria (at least five volunteers and a unimodality program), telephone interviews were completed with administrators of 123 or 89 percent of the eligible programs. In addition, telephone interviews were conducted with administrators of 15 programs that did not have volunteers but satisfied the same criteria and sampling variables.

The 138 programs selected represent the universe of unimodality programs using significant numbers of volunteers. Consequently, data from the 123 programs participating in the study can be viewed as reflecting the concerns and issues of all unimodality programs with large volunteer staffs.

Phase II - On-Site Survey

Site visits were made to 15 of the 123 programs whose administrators had been interviewed in Phase I. Criteria for selection were programs with a substantial number of volunteers in both specialized and nonspecialized categories including, wherever possible, volunteer counselors. Programs were distributed across the four regions of the country with at least one DF and TC program in each region. In all, nine DF and six TC programs were visited. Methadone programs were not included in the site visits because of their limited use of volunteers.

Limitations of the Study

The fact that multimodality programs were not included in the study could be considered a limitation. While it could be assumed that the responsibilities of volunteers would be similar, attitudes of volunteers in multimodality programs could differ.

Only two MM programs were studied. Very few MM programs had at least five volunteers, and most were parts of larger multimodality programs. Only six MM programs met the specified criteria.

Clients were not interviewed for the study, so it was not possible to ascertain their attitudes toward the volunteers and the quality of service they felt they received.

Questionnaires and Interviews

Four questionnaires were used to interview the following four groups: (a) administrators of 123 programs that had at least five volunteers, (b) adminstrators of 15 programs without volunteers, (c) 51 paid counselors in 15 programs[2], and (d) 108 volunteers in these same 15 programs. Each questionnaire was highly structured and dealt with respondent demographics as well as volunteers' function, background, training, experience, and perceived impact.

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[2]Some of the paid counselors were also responsible for supervisory functions.

Data Analysis

Because of the nature of the study, the statistics are typically descriptive. Volunteer functions are reported separately for DF and TC programs, as well as in the aggregate, whenever they varied with the type of program. With regard to stratification by modality in Phase I, of the 123 programs with completed interviews, 95 were DF; another 26, TC; and 2, MM. Because of the dearth of MM programs, only DF and TC data are reported separately; aggregates include the two MM programs. Other subgroup analyses (e.g., by demographics) generally did not reveal differences in either Phase I or Phase II. Only when the differences were evident are they discussed in this report.

Findings

Volunteer Background and Characteristics

The 108 volunteers interviewed in Phase II (on-site portion) of the survey were classified into three occupational groups: (1) specialized professionals (N=31) with backgrounds as physicians, lawyers, psychiatrists, nurses, social workers, etc.; (2) counselors (N=47) with or without academic degrees who were mainly responsible for counseling, and (3) noncounseling personnel (N=30) such as administrative support staff, tutors, and hotline counselors. Forty-nine of the volunteers were male, and 59 were female. They had a median age of 31 and mean age of 33. The overwhelming majority of volunteers (92.5 percent) were white. Two-thirds had B.A. degrees or above, 41.8 percent were students, 56.4 percent were single, (i.e., never married, separated, or divorced), and 65.7 percent were employed as paid workers elsewhere.

Among the 31 professionals, 67.7 percent were male, while only 36.2 percent of the 47 counselors were male. Sixteen percent of the counselors and 16.6 percent of the volunteers in noncounseling functions reported addiction backgrounds, while none of the professionals reported such.

Training and experience. More DF than TC administrators reported that volunteers in their programs had prior experience in other drug abuse programs. Fully 25 percent of TC administrators reported that none of their volunteers had previous experience, while fewer than 10 percent of DF administrators did so.

All 106 programs that had volunteer counselors provided in-service training. The majority of both counselor and noncounselor volunteers had at least one college course in counseling and other relevant topics. Furthermore, 44 percent of these volunteers had received training in counseling through previous programs in which they had worked.

The counselor group appeared to be somewhat better trained than the noncounseling group, especially on the effects of drugs and on drug laws and their enforcement. It should be noted that all but one of the programs sampled also supervised volunteer counselors continuously. Most of the programs assigned a staff member direct responsibility for the treatment provided by volunteers to their clients.

Specialized professionals generally received program training, or at least an orientation to the program dealing with drug abuse and treatment. Health professionals, moreover, tended to have taken a number of courses in psychology and other counseling-related topics during their undergraduate or postgraduate careers.

Hours of work. The median number of hours worked by volunteers in the sampled programs was about 10 per week. However, professionals were much more likely to work only a few hours a week, while counselors were likely to work well beyond the 10-hour median.

Length of time worked as a volunteer. Half the volunteers interviewed had worked for less than 2 years in their program. Fewer than 25 percent had worked more than 4 years at the current program, and none had worked longer than 9 years. As one might expect, those who had worked in the program longer were less likely to be students and more likely to be older and employed. Professionals were more likely to have been volunteers longer than the counseling and noncounseling volunteers.

Volunteer job satisfaction. High levels of satisfaction were expressed by volunteers with their program roles. Indeed, all volunteers reported that they were satisfied or very satisfied with their roles. The most frequent reasons for this high degree of satisfaction were fulfillment and enjoyment from helping others, enjoyment of coworkers, and enjoyment of putting one's skills to work.

No volunteers planned to leave the programs because of any dissatisfaction, and the vast majority felt that volunteers were needed and well accepted by administrators, clients, and counselors alike. In particular, 81 percent of the volunteers saw themselves as well accepted by administrators as people to help with program policy making and planning. Eighty percent thought they were well accepted by paid counselors in terms of giving client services. Further, 96 percent gave the same judgment about clients' acceptance of volunteers. Counselors substantiated this by reporting that client feedback concerning the volunteers was positive. It should be noted that few volunteers suggested any substantial need for improvement in their situations, although one-third felt that more client contact would increase their job satisfaction.

Sources and types of volunteers. Administrators were asked the extent to which five sources of volunteers were tapped: colleges, community organizations, advertising in the media, former clients of the program, and former clients of other programs. The most frequently cited sources across modalities were colleges (88 percent), followed by community organizations (76 percent) and former clients from the program (74 percent).

The majority of volunteers interviewed first heard about the programs' need for volunteers through friends, family, or their own experience with the program. Other information was transmitted through teachers, employees, or other school/work related individuals (23 percent), the media (9 percent), or direct explorations such as calls by respondent or program (5 percent).

Most volunteer counselors (85 percent) made the first contact with the program. For volunteer professionals, however, it was about evenly divided as to whether the program or the volunteer made the initial contact.

Differences emerged between modalities in the source of volunteers. Colleges were the most frequent source for DF programs; former clients for TC programs.

Motivation for volunteering. Two sets of motives are often contrasted, each thought to be primary in attracting volunteers. These sets may be summed up as "altruism" on one hand, and "self-improvement" on the other. In this study both were found to be operative. Volunteers were given several choices of "main motivations" to volunteer in the first place. In order of frequency of choice, 83 percent said they desired to help people and to help with a societal problem, and 65 percent wished to learn something new. More than half (57 percent) wished to pick up experience for later job opportunities. Curiosity (18 percent) and available time (17 percent) were far behind in frequency of choice. It would seem therefore that recruiting strategies need to take account of altruistic and self-actualization motives.

Professionals reported altruistic motives more frequently than the other groups. Counselors on the other hand were very much concerned with gaining knowledge and experience for the future.

Only about one-third of the respondents volunteered for their particular program specifically because it was a drug abuse program. About half the volunteer counselors said they did so partly because of a personal, family, or friend's experience with drugs. Only one professional reported such an experience as a motivator.

Selection of volunteers. Numbers of applications and screening activities varied widely across programs. Three-quarters of the programs received over 20 applications (median=30). The median of acceptance was 51 percent; only one-fifth of programs accepted over 75 percent of the applicants.

Distribution of Volunteers and Paid Staff

Total number of volunteers. The 123 programs with at least 5 volunteers had a median of just under 25 volunteers per program. When considered by modality, the medians were 29 and 14 for the DF and TC modalities, respectively (see table 2 for a summary of the distribution of numbers of volunteers in the program).

Volunteers versus paid staff. The percentage of sampled programs having at least one volunteer in each staff category listed in table 3 was determined. The same was done for paid staff. Eighty percent had at least one volunteer counselor, and 92.6 percent had at least one paid administrative support person. Over half the programs had both paid and volunteer counselors and support staff.

Table 2.--Distribution of number of volunteers in programs

Total number of volunteers in programs

Total number of volunteers	Percent of programs
N=4,699	N=123
5 to 10	16.3
11 to 15	17.1
16 to 20	8.9
21 to 30	16.3
31 to 50	13.8
51 to 75	13.0
75 to 100	6.5
Over 100	8.1

Total number of volunteers by modality

Total number of volunteers	Percent of programs	
	DF	TC
N=4,699	N=95	N=26
5 to 10	11.6	30.8
11 to 15	16.8	19.2
16 to 20	8.4	11.5
21 to 30	14.7	19.2
31 to 50	14.7	11.5
51 to 75	15.8	3.8
75 to 100	8.4	0.0
Over 100	9.5	3.8

Table 3.--Percentage of programs[1] having paid staff and/or volunteers by staff category

Staff category	Percent of programs with at least one volunteer			Percent of programs with at least one paid staff member	Percent of programs with paid and/or volunteer staff			
	All programs	DF N=95	TC N=26		Both	Paid only	Volunteer only	Neither
Physician	27.3	29.5	23.1	18.2	5.8	12.4	21.5	60.3
Psychiatrist	26.7	26.6	26.9	24.6	3.3	21.3	23.0	52.5
Lawyer	61.8	62.1	61.5	13.8	11.4	2.4	50.4	35.8
Psychologist	39.0	42.1	30.8	48.8	21.1	27.6	17.9	33.3
Social Worker (MSW)	33.3	36.8	19.2	30.1	13.8	16.3	19.5	50.4
Vocational Counselor	24.3	24.2	23.1	18.3	3.5	14.8	20.9	60.9
Nurse	34.1	39.9	15.4	21.1	12.2	8.9	22.0	56.9
Counselors	80.5	76.8	92.3	89.4	71.5	17.9	8.9	1.6
Counselor with at least bachelor's degree	68.3	67.4	69.2	84.6	56.9	27.6	11.4	4.1
Counselor without bachelor's degree	44.7	38.9	69.2	49.6	25.2	24.4	19.5	30.9
Hotline Worker	46.3	54.7	19.2	2.4	2.4	0.0	43.9	53.7
Administrative Support Staff	57.9	50.5	80.8	92.6	52.1	40.5	5.8	1.7

[1] N=123; includes two methadone maintenance programs.

Over 60 percent of the programs had at least one volunteer lawyer, more than any other specialized professional. Half the programs had only volunteer lawyers.

Psychologists were the next most common specialized volunteers in each modality.

Those programs that used staff in specialized categories were more likely to have "volunteer staff only" in the categories of physicians, psychiatrists, vocational counselors, social workers, nurses, and lawyers than to have "paid staff only."

Hotline counseling appears to be a volunteer function. No programs sampled had "paid only" hotline staff, and only 2.4 percent of the programs had both paid and volunteer staff. About 95 percent of the programs with hotlines used only volunteers for that service.

Functions of Volunteers

More than half of all volunteers were involved in counseling clients in individual sessions. Less than one-third of the volunteers had more extensive personal contact with clients, such as providing social activities, working with clients in the community, and providing personal aid to clients. In contrast to these overall figures, more than one-third of the volunteer professionals counseled clients, while more than half participated in program administration.

Students reported involvement in a greater number of program activities than did other volunteer groups. As might be expected, they were less involved than nonstudents in program administration.

Those who reported addiction backgrounds were more likely to facilitate and provide client social activities. They are evidently seen as peers of the clients and therefore appropriate for this role.

Those who volunteer in outpatient drug free settings are more likely than those in therapeutic communities to provide hotline counseling and to perform administrative activities such as clerical and service duties, filling out client forms, learning about community resources, and doing staff training. Volunteers in TCs were more likely than volunteers in DF programs to report themselves as facilitating and providing client social activities.

It is noteworthy that while over 80 percent of DF program administrators reported that volunteers spent time becoming familiar with community resource agencies to learn where to make referrals, only 40 percent of TC administrators reported volunteer activity in this area. Moreover, in fully 70 percent of DF programs, volunteers participated in training, while this was so for only 46 percent of the TC programs. The high educational level of DF volunteers may partially explain these differences. Length of service was also associated with assignment. In both modalities length of volunteer service (which was, of course, correlated with age) was positively correlated with assignment to administrative functions as opposed to direct client service activities.

Specialized volunteers. Volunteer professionals were more likely to provide consultation to counselors about clients or to see clients on a temporary basis than to have clients of their own in the program. This pattern held for volunteer psychiatrists, psychologists, and vocational counselors. Lawyers were far more likely to be consulted about legal problems than to represent clients in court. In contrast, physicians most frequently provided direct medical care to clients during the course of treatment. Also, in over half the DF programs with MSW volunteers, the MSWs had clients of their own.

The specialized volunteers brought to the program more than just their own services. Administrators mentioned that volunteers in every speciality procured resources from the community for the program by organizing other specialists of the same type for the program, by referring clients outside the program for services, and by obtaining funding. In a similar vein, specialized volunteers of all types were involved in community relations and community education, though this was mentioned less frequently than the procuring of services.

Another consistent theme across types of specialists was their participation in the administrative functioning of the program. Volunteers served on Boards of Directors and participated in policy development, planning, and evaluation. Moreover, psychologists, psychiatrists, and MSWs participated heavily in in-service training of counselors.

Only MSWs showed a marked discrepancy in the availability and use of volunteer professionals between modalities. Very few TCs relative to DF programs had MSWs, and the MSWs in DF programs were much more involved in service delivery to clients and their families than were those in TCs.

Volunteer counselors. Most of the 123 programs in the telephone survey had volunteer counselors, with only 23 percent and 8 percent of the TC and DF programs, respectively, having no volunteer counselors; both MM programs had volunteer counselors. Eleven programs in the study had only volunteer counselors, and 22 used paid counselors exclusively.

In addition to volunteer counselors, over half the DF programs had volunteer hotline workers for over-the-phone counseling. In contrast, only 20 percent of TC programs and no MM program had any volunteers who served this function. Only 2 percent of programs that had hotline workers had paid staff in that capacity.

Noncounseling volunteer functions. The largest number of noncounseling volunteers functioned as administrative support staff, defined as individuals who deal with the administrative and business functions of the program rather than the therapeutic functions. Volunteers were used in half the DF programs and fully 80 percent of TC programs as well as in both MM programs. Even with the high rate of volunteerism in this category, only 5.8 percent of all programs left the administrative function wholly to volunteers, less than any other category.

Noncounseling volunteers could be divided into those who provide services directly to clients and those who provide services to the program. The former function occurred substantially more often in TC programs; the latter, in DF programs. Five different services to clients were identified: (1) social services and psychological care (19.8 percent), (2) recreation and entertainment (13.5 percent), (3) support services, e.g., cooking, driving (10.3 percent), (4) training and skill development (8.7 percent), and (5) physical health care (4.8 percent). Four services to the program emerged: administrative functions, such as membership on Boards of Directors, governing committees, and community Boards (13.5 percent); consultation to the program (12.7 percent); provision of resources and community contact for the program (12.7 percent); and provision of support for the business side of the program, such as accountant or bookkeeper (4.0 percent).

Table 4.--Evaluation by paid counselors of potential and/or actual volunteer performance

(N=51 counselors)

Activity	A[1] Percent indicating volunteers have been involved in activity	B[2] Mean rating of actual or potential performance 4 = excellent 1=poor	C[3] Percent believing activity could be performed by volunteers only
Providing community education, that is, talking to community groups about drug abuse and drug abuse treatment.	68.0%	3.26(.12)[4] (12.8%)	62.7%
Performing clerical and service tasks, such as typing letters, answering phones, carrying messages, or cleaning and making repairs.	92.2	3.16(.11) (13.7%)	59.2
Filling out forms which deal with client admission, progress, or discharge.	68.0	2.91(.14) (26.1%)	33.3
Managing clients in the center, from the point of view of controlling and coordinating client traffic or disciplining clients.	76.0	2.80(.14) (25.5%)	36.7
Providing social activities for clients under the auspices of the program, for example, a picnic for clients in the program.	63.3	3.20(.10) (15.6%)	70.8
Working with clients in the community, for example, visiting clients at work, accompanying them on job interviews, visiting them in the hospital, or appearing for them in court.	48.0	2.94(.11) (28.3%)	43.8
Becoming familiar with community resource agencies in order to know exactly where to send clients for these services in the community.	72.5	3.20(.12) (23.4%)	66.7
Providing personal aid to clients, for example, accompanying them to community resource agencies, helping them out at home, or helping them deal with people in their neighborhoods.	68.6	2.92(.13) (25.5%)	52.1
Administering clients, that is, deciding whether clients will be accepted into the program, what the clients' treatment regimen will be, and whether the clients should remain in the program.	43.1	2.50(.16) (52.1%)	[illegible]
Discussing client treatment and progress in staff meetings.	86.3	3.00(.12) (22.4%)	19.6
Administering other staff members in the program, for example, making out work schedules, making staff decisions.	38.0	2.32(.17) (57.4%)	30.0
Administering the program, for example, making up budgets, reviewing and revising program policies, evaluating effectiveness of services provided.	49.0	2.29(.18) (57.4%)	12.2
Counseling clients in individual counseling sessions.	88.2	2.96(.14) (26.5%)	29.4

Table 4.--Evaluation by paid counselors of potential and/or actual volunteer performance--con.

Activity	A[1] Percent indicating volunteers have been involved in activity	B[2] Mean rating of actual or potential performance 4 = excellent 1=poor	C[3] Percent believing activity could be performed by volunteers only
Counseling clients in group counseling sessions.	86.3	2.88(.12) (28.5%)	25.5
Doing hotline counseling over the telephone.	63.3	3.16(.15) (18.4%)	59.6
Administering and interpreting psychological tests.	35.3	2.43(.20) (47.5%)	30.[illegible]
Training other staff members, for example, explaining procedures and rules to new staff members, participating as instructors in training programs.	60.8	2.98(.17) (29.1%)	42.9

1 Question A: "Since you've worked in this program, have volunteers ever been involved in ACTIVITY?"
2 Question B: "(If volunteers were to do this), how would rate the (likely) quality of their performance? Would it be excellent, good, fair, or poor?"
3 Question C. "Could this function be satisfactorily performed if only volunteers were involved?"
4 Number in parentheses beside mean rating is standard error of the mean. Number in parentheses below rating is percentage of counselors rating performance as fair or poor.

Comparison of Volunteer and Paid Staff

When the activities of volunteers and paid staff are compared, the differences between the two groups are largely of degree rather than kind. Areas of significant volunteer involvement (e.g., counseling, community education, clerical duties) are also areas of significant paid staff involvement.

However, a clear differentiation between paid and volunteer staff occurred in all areas of administration. Volunteers were less often involved in administrative functions than paid staff and least often involved in such duties relative to all other tasks they performed.

In addition, while all paid counseling staff were reportedly involved in working with community agencies and providing elements of in-service training/orientation, volunteers were less likely to provide these services.

Volunteer aid to counselors. As noted above, volunteer professionals often provide technical information and/or services to the paid counseling staff of a program. Paid counselors were asked to describe their requests for such aid and their satisfaction with the outcomes of these requests.

In the 15 programs investigated in Phase II, counselors (N=51) had most often worked with psychologists (61 percent), followed by lawyers (41 percent). These were also the two most frequently occurring types of volunteer professionals in treatment programs. At the other end of the continuum, paid counselors reported least experience working with MSWs and vocational counselors (29 percent and 16 percent, respectively).

A clear pattern emerged across categories of volunteer professionals with regard to the type of requests volunteers made to them. Counselors were much more likely to ask for information from a specialist for use in working with a client (87 percent) than to request that the specialist actually see the client (58 percent). The only exception was vocational counselors who were requested to see clients.

Paid counselors' rating of volunteers. When paid counselors were asked to rate volunteer job performance (real, if observed; estimated, if not observed), over two-thirds of the counselors reported volunteer performance to be good or excellent. However, ratings varied across activities (see table 4).

Volunteers received their highest ratings from paid counselors on activities which involved superficial or no contact with clients, or which were not central to the counseling function or to the management of the program. These included providing community education, spending time becoming familiar with community resource agencies which might serve clients, performing clerical and service tasks, providing social activities for clients, and providing hotline counseling.

Where activities involved greater contact with clients, e.g., controlling and disciplining clients in the center or group counseling of clients, ratings of volunteer performance declined somewhat, though not substantially. Slightly over a quarter of the counselors rated individual and/or group counseling by volunteers fair or poor.

Volunteers received their lowest ratings on activities involving adminstration of the program, staff, and clients. For these activities, over half the counselors rated actual or potential performance of volunteers as fair or poor. It is of interest to note that these activities were reported both by the administrators and by counselors to be ones in which volunteers had low levels of actual involvement.

There was very close correspondence (R=85) between performance ratings and judgments by counselors as to whether particular activities could be handled by volunteers alone. Over half the counselors believed that providing community education, becoming familiar with community resource agencies, providing social activities for clients, doing hotline counseling, and performing clerical and service tasks could be done by volunteers alone. In contrast, only about a third or fewer of the counselors felt that volunteers could completely take over individual and/or group counseling, controlling and disciplining clients in the center, and filling out forms dealing with client admission, progress, and discharge, or discussing client treatment and progress in staff meeting. Administrative functions received the lowest rating in this regard.

Activities by volunteers which were central to the counselors' activities received very low ratings. This is exemplified by the 70.8 percent of counselors who believed that volunteers could completely take over the provision of social activities for clients as opposed to 27.4 percent who thought volunteers could take over counseling.

Paid counselors who endorsed interaction between clients and nonspecialized volunteer counselors (N=49) were asked to specify the level of supervision of volunteers they felt was required. For recreational activities with clients, the vast majority of counselors felt that only intermittent supervision was required. However, half the counselors felt that almost constant supervision was required for volunteers counseling clients. These responses mirror paid counselors' views of the capability of volunteers in handling recreational versus counseling activities with clients.

When asked to compare paid and volunteer counselors on a number of dimensions, over 70 percent of paid counselors felt volunteer counselors were less knowledgeable about drugs. Moreover, 44.7 percent of the paid counselors reported volunteer counselors to be less dedicated, and 46.8 percent felt they were less able to take responsibility in the program (see table 5).

Drug use among volunteers and paid counselors. Both administrators and paid counselors were asked about the drug use history of the volunteers (see tables 6, 7, 8, and 9). Fully 83 percent of administrators indicated that some proportion of their volunteers had used drugs on a regular basis prior to becoming volunteers. Paid counselors gave similar estimates of the history of drug use by volunteers. Administrators took a moderate or

Table 5.--Paid counselors' opinions on volunteer counselors' abilities

(N=47[1])

Question	Percent		
	More	Equal	Less
"Are the volunteers more knowledgeable, equally knowledgeable, or less knowledgeable about drugs than are paid counselors?"	2.1	25.5	72.3
"Do the volunteers have more empathy, equal empathy, or less empathy towards clients than do paid counselors?"	8.7	65.2	26.1
"Have the volunteers themselves been more involved, equally involved, or less involved in the drug culture than have paid counselors?"	13.3	42.2	44.4
"Are the volunteers more able to take responsibility, equally as able to take responsibility, or less able to take responsibility in the program than are paid staff?"	2.1	51.1	46.8
"Are the volunteers more dedicated, equally as dedicated, or less dedicated than paid counselors to the program misssion?"	8.5	46.8	44.7

[1]Four of the 51 paid counselors interviewed were in a program which had no volunteer counselors.

Table 6.--Administrators' estimates of volunteers' histories of drug use

(N=123)

	Percent
All	3.3
Most	8.9
Some	30.1
A few	40.7
None	13.0
Refused to answer	1.6
Don't know	2.4

even positive view of the prior drug use history of volunteers, believing either that prior drug use did not interfere with current volunteer work or that it actually facilitated understanding.

Volunteer counselors were asked specifically about their own drug use. They reported a wide range of experience with drugs, although slightly less usage for most drug categories compared to paid counselors. Experience ranged from a low of 8 percent for lifetime use of heroin to more than 80 percent for marijuana and alcohol to excess. Sixteen percent of all volunteer counselors considered themselves ex-addicts. Fourteen of the 123 programs drew all their volunteers from the population of former treatment clients.

Table 7.--Administrators' estimates of number of volunteers with history of drug abuse treatment

(N=102)

	Percent
All	16.7
Most	3.9
Some	13.7
A few	34.3
None	28.4
Refused to answer	1.0
Don't know	2.0

Nearly all paid counselors reported that they had used marijuana at least once; two-thirds, more than 10 times. At least two-thirds had tried hallucinogens, cocaine, amphetamines, barbiturates, and/or other sedatives, hypnotics, and tranquilizers, with at least one-third of the counselors reporting use of these drugs on more than 10 occasions. One-sixth had used heroin more than 10 times. More than two-fifths (46.2 percent) had been in treatment previously for drug abuse, and more than half (53.8 percent) considered themselves to be ex-addicts.

Attitudes of administrators who have no volunteers in their programs. Administrators who had no volunteers in their programs were also interviewed

Table 8.--Administrators' attitudes about the drug use history of volunteers

(N=123)

	Percent
"Volunteers ideally should have no history of drug use or drug treatment."	4.9
"Previous use of drugs by volunteers does not interfere with their work in the program."	44.7
"Previous use of drugs by volunteers makes them better able to understand the problems of drug abuse."	39.0
No opinion	2.4
Don't know	4.1
No answer	4.9

Note: "No answer," "no opinion," and "don't know" are documented because of the sensitive nature of the questions.

in this study. Programs were selected randomly within the strata already established for the larger study. In all, 15 adminstrators were interviewed--5 MM, 6 DF, and 4 TC. Effort was made to understand their perceptions of the benefits and/or limitations of vounteers and their reasons for not using them.

The attitudes of these administrators toward the use of volunteers were quite favorable, although some reservations were expressed about the training and experience necessary to do counseling. The most frequently given reason for not hiring volunteers was that they were unavailable. However, few of the administrators questioned had actually attempted to recruit volunteers. Not surprisingly, it appeared that when administrators believed they had sufficient paid staff and also perceived logistical problems in hiring, recruiting, training, and supervision of volunteers, little effort was made to obtain volunteers.

Table 9.--Paid counselors' estimates of number of volunteers with history of drug abuse

(N=50)

	Percent
Most	6.0
Some	30.0
A few	48.0
None	16.0

Summary and Conclusions

Volunteers were divided into three types: specialized professionals, counselors, and noncounselors who worked in administrative support activities. Differences in extent to which volunteers were employed varied with type of volunteer and treatment modality. Of the specialized volunteers, lawyers and psychologists were used most frequently by programs. In addition, lawyers stood out as a special category in that they were more likely to serve as volunteers than as paid staff. The most frequently cited source for volunteer recruitment was colleges, followed by community organizations and former clients from the program. Many first heard about the programs' need for volunteers through friends, family, or their own experiences with the program. Motivations for volunteering can be summarized as either altruism or self-improvement. Professionals reported altruistic motives whereas counselors were concerned with gaining knowledge and experience for the future. It should be noted that all programs with volunteers provided them with in-service training, and most had a paid staff member directly responsible for the volunteers. Activities of volunteers mirrored that of paid staff with differences in degree of activity rather than kind. In addition, activities differed somewhat by treatment modality.

There was a consistently positive response of administrators, paid counselors, and volunteers regarding the role and activities of volunteers, the single exception being paid counselors' lower rating of volunteers' delivery of counseling services. That finding points up the importance of providing orientation to paid counseling staff regarding the roles and functoning of volunteers.

In summary, with volunteers constituting 17 percent of the drug treatment staff, their role is a vital and necessary one which appears to enhance services to the client. Without volunteers, it can be assumed that client services would suffer. This study attests to the success of volunteers in the field of drug abuse. On the other hand, it also opens questions not addressed in this report concerning the field's dependence on volunteers and lack of sufficient funding for paid staff.

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